May 6, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0956-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient was approximately 56 years of age when he sustained an injury at work on ___. He was in the process of pulling materials up with a pulley and rope when he began having pain in his right upper extremity. This continued. He was later seen medically, felt to have been ulnar neuritis at the cubital fossa, substantiated by electrodiagnostic testing, and he eventually underwent ulnar nerve transposition surgery in late October 2002. Afterward he had a large amount of physical therapy. This patient had also been noted to have a previous lack of full flexion and extension of the elbow from an old fracture, sustained in approximately 1977.

Much time has passed, along with much physical therapy.

Because the patient has ongoing pain and sensory symptoms in the limb, a further intensive program has been requested in the form of a six-week, five days per week work hardening program.

REQUESTED SERVICE

A work hardening program is requested for this injured worker.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that this patient is not an appropriate candidate for the requested work hardening program. Realistic and likely attainable goals have not been established.

It is noted on his medical visit of 4/8/03 with the physician that the patient continued with complaint of "constant numbness in the fourth and fifth fingers," and also "pain and numbness at the medial elbow traveling down the medial forearm into the medial right hand." These limb sensory complaints are not problems with a reasonable chance of being significantly altered by a six-week work hardening program.

Contact with employers is sometimes required to ascertain the possibility of return to work with certain restrictions. It was already shown the patient could function at medium work level activities. A return to work with some restrictions would likely be superior to an attempt to eliminate the pain and sensory complaints in an artificial work hardening environment.

___ is now seven months post-surgery, and any likely further sensory changes and hopefully improvements will be slow and very gradual in development. The reviewer does not find justification for the requested thirty work hardening sessions for this patient who has already been progressed through much time and physical therapy.

The reviewer also agrees with a previous review by ___ who felt that the details of the actual physical demands of this patient's particular job vs. his current physical capabilities were not satisfactorily delineated, nor were the goals and realistic six-week work hardening objectives satisfactorily presented.

With specific reference to the TWCC Medical Fee Guidelines (referring to Rule 134.201), the reviewer does not find that this patient would receive adequate benefit from the program, enough to significantly effect his current level of functioning.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 6th day of May 2003.